YOUR PERSONAL PLAN:
Relapse Prevention

Patient Name: **Study ID:**

CONTACT INFORMATION

Primary Care Physician: **Tel. N2: ( )**

Depression Nurse Specialist: **Tel. N2:( )**

Psychotherapist: **Tel. N2:**

PERSONAL WARNING SIGNS

1.
2.
3.

STRESSFUL LIFE EVENTS AND How TO MINIMIZE THEM

Event: **How to minimize:**

Event: **How to minimize:**

Event: **How to minimize:**

MEDICATIONS

Name of antidepressant: **Dose:**

Take medication until:

Questions: Call your primary care clinician or your depression nurse specialist.

(See Contact Information, above)

WHAT YOU SHOULD Do IF SYMPTOMS OF DEPRESSION RECUR

2.

Reviewed by. *_ (Signature of MD/Primary Care Clinician)*

ORIGINAL **- STUDY RECORD** *YELLOW-* **MDIPRIMARY CARE CUNICIAN** **PINK-PATIENT** *GOLDENROD* **- OTHER**